SOUTH CAROLINA
STATE ACCIDENT FUND

HARRY B. GREGORY, JR., Director

Enclosed you will find State Accident Fund's Mileage Reimbursement Form for your use, which you may copy, if necessary. Complete the form using black or blue ink. Mail the original completed form directly to us at the address listed below. DO NOT FAX the form to our office.

In addition, we will not reimburse mileage to pick up prescriptions. We do reimburse mileage for authorized medical treatment which is MORE than 10 miles round trip.

Post Office Box 102100 Columbia, South Carolina 29221-5000 (803) 896-5800 FAX (803) 896-5828

State Accident Fund

Mileage Reimbursement Form

Injured Worker Name:	**Claim No:**
Home Address:	**Phone No:**
Employer:	**Date of Injury:**

Mileage must be more than 10 miles round trip *Mileage will not be paid for travel to the drug store*

DO NOT FAX!

Reimbursement Rate: 01/01/01 to 06/30/06 = .345; 07/01/06 to 06/30/08=.445; 07/01/08 to Present = .505

Date of Trip	Destination: Include address of starting point along with the name of the doctor, hospital, physical therapy and address of the facility.	Round Trip Miles	Rate	Total **SAF use only**
	From: To:			
	From: To			
	From: To			
	From: To			
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	From: To:			
	From: To:			
	From: To:			
	From: To:			
	From: To:			
	From: To:			
	From: To:			

Signature of Injured Worker: _____ Date:_____